

APPENDIX A

CDBG PROJECT PROPOSAL

(Office Use Only)

SAN BERNARDINO COUNTY
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT
COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) PROGRAM

- PUBLIC SERVICE PROGRAM PROPOSAL -

Public service programs involve the use of CDBG funds to pay the non-construction costs of providing services such as: graffiti removal, social services, transportation services (in support of qualified social services); employment, housing, legal, health and education services; and blight abatement.

Carefully read through the instructions and proposal forms. Answer all questions which are applicable to your project as specifically and completely as possible. If more space is needed, attach separate sheets.

TYPE OR PRINT.

A. APPLICANT INFORMATION

- 1) Name of Applicant: Friendly Faces Homeless Services, Inc.
- 2) Mailing Address: 1234 "A" Street
Anytown, CA Zip: 92001
- 3) Contact Person: Jane C. Doe
- 4) Title: Executive Director
- 5) Phone: (909) 555-3456 Date Submitted: December 6, 2004

B. PROJECT DESCRIPTION

- 1) Using 25 words or less, provide a concise description of the proposed program. **This 25 word description is required in order for this application to be considered complete.** Consider items addressed under the General Project Eligibility section of the Project Proposal Instructions. A detailed project description is also required to be provided on Attachment A, page 5 of 5.

FFH will provide homeless shelter services in the East Valley area of San Bernardino County and will expand services to include counseling and job training assistance.

PUBLIC SERVICE PROGRAM PROPOSAL

C. PROJECT CHARACTERISTICS

- 1) Street address and nearest cross streets of the site or office where the program will be carried out:

1234 "A" Street, Mentone

- 2) Legal property owner: **Friendly Faces Homeless Services, Inc.**

- 3) Local zoning restrictions that would affect the program: None

- 4) Conditional use permit required? Yes X No

If yes, attach a copy of the permit. If no, explain why.

- 5) Description of the community need(s) addressed by this proposal:

Clients are homeless persons from the Mentone, Redlands, and Yucaipa areas.

- 6) Describe the geographic boundaries of the neighborhood, community or area in which clients of the proposed program reside (attach a map if needed):

- 7) Estimated number of people to be served: **250 - 300 homeless persons per year**

- 8) The proposed Community Service would be provided to:

<u>X</u>	Low- and moderate-income persons or households
<u> </u>	Abused children
<u> </u>	Handicapped persons
X	Illiterate persons

	Battered spouses
<u>X</u>	Homeless persons
	Migrant farm workers
	Elderly persons

- 9) Name and non-profit corporation status of the non-profit agency to provide the proposed service (subrecipients must be incorporated public or private non-profit organizations): **Friendly Faces Homeless Services, Inc. is a registered**

incorporated non-profit agency

- 10) Federal I.D. Number or Social Security Number of the non-profit organization:

95-288896156

PUBLIC SERVICE PROGRAM PROPOSAL

D. PROPOSED PROGRAM BUDGET

	<u>CDBG Share</u>	<u>Other Source</u>
Personnel	\$ <u>23,300</u>	\$ <u>45,000</u>
Equipment	\$ <u>-0-</u>	\$ <u>10,000</u>
Consultant Services	\$ <u>5,200</u>	\$ <u>-0-</u>
Space Rent	\$ <u>-0-</u>	\$ <u>-0-</u>
Audits	\$ <u>1,500</u>	\$ <u>-0-</u>
Other	\$ <u>-0-</u>	\$ <u>15,000</u>
Total Costs	\$ <u>30,000</u>	\$ <u>70,000</u>
Grand Total (CDBG + Other)	\$ <u>100,000</u>	

Estimator (name and title): Jane C. Doe, Executive Director

E. AMOUNT OF CDBG FUNDS REQUESTED

- 1) Amount of CDBG funds requested in this application. \$ 30,000
- 2) Additional funds to be provided by Other Source(s) for this project. The date that the Other Source(s) of funds have been or will be awarded and available, must be stated below:
- Source(s): United Way \$ 40,000
- Award Date: October 200-
- Date Available: January 200--
- Source(s): Private Donations/Fundraisers \$ 10,000
- Award Date: ongoing
- Date Available: ongoing
- Source(s): Emergency Shelter Grant \$ 20,000
- Award Date: July 200-
- Date Available: October 200-
- Total of **Other Sources** \$ 70,000

- 3) Authorized Signature: To the best of my knowledge, the information provided in this application is true and I am authorized to submit this application on behalf of the applicant agency.

Name: _____ Phone: _____

Signature: _____ Date: _____

PUBLIC SERVICE PROGRAM PROPOSAL

F. BENEFIT AREAS

This section requires a break down of the requested CDBG funds by the geographic area to be covered by the proposed public service. Only address those areas where you intend to provide primary service.

- 1) **Cooperating Cities:** The following cities participate as cooperating cities in the County's CDBG program. Please determine if the primary service area for your proposed service would include one or more of the following cities. If the service would provide predominate or partial benefit to city residents, the County will request a funding recommendation from the benefiting city or cities. Enter the requested amount of CDBG funds needed to provide the proposed service to each applicable city. Sub-total your entries below.

	<u>Amount Requested</u>		<u>Amount Requested</u>
Adelanto	\$ _____	Loma Linda	\$ _____
Barstow	\$ _____	Montclair	\$ _____
Big Bear Lake	\$ _____	Needles	\$ _____
Chino Hills	\$ _____	Redlands	\$ 6,000
Colton	\$ _____	Twentynine Palms	\$ _____
Grand Terrace	\$ _____	Yucaipa	\$ 9,000
Highland	\$ _____	Town of Yucca Valley	\$ _____
Funds Benefitting Cooperating Cities:Sub-total			\$ <u>15,000</u>

- 2) **Unincorporated Regions:** The following regions contain unincorporated areas covered by the County CDBG program. Please determine if the primary service area for your proposed project includes one or more of the following unincorporated areas. Enter the requested amount of CDBG funds needed to provide the proposed project to each applicable unincorporated area. Sub-total your entries below.

	<u>Amount Requested</u>
Searles Valley and vicinity	\$ _____
Hinkley/Lenwood/Newberry Springs/Baker and vicinity	\$ _____
Colorado River areas	\$ _____
Oro Grande/Unincorporated Victor Valley areas	\$ _____
Phelan/Pinon Hills/El Mirage and vicinity	\$ _____
Lucerne Valley and vicinity	\$ _____
Johnson Valley/Landers/Morongo Valley and vicinity	\$ _____
Joshua Tree and areas to the north and east	\$ _____
Lake Arrowhead/Running Springs/Big Bear Valley areas	\$ _____
Crestline/Cedarpines Park/Wrightwood	\$ _____
West Fontana/Lytile Creek/Devore	\$ _____
Mentone	\$ _____
South Montclair/Dairy Preserve area	\$ _____
Muscoy/North Norton/Bloomington	\$ _____
Other, Please specify _____	\$ _____
Funds Benefitting Unincorporated Regions:	
Sub-total	\$ <u>15,000</u>

- 3) **Total Funds:** The total amount of CDBG funds requested in Section F, (Cooperating Cities + Unincorporated Regions). This amount must equal the amount of CDBG funds requested in this application on Line 1, Section E.

Total Funds Requested **\$ 30,000**

DETAILED PROJECT DESCRIPTION

(Continuation of Section B, Project Description, Page 1 of 5)

Within the space provided on this page, provide any additional information needed to fully describe the proposed public service, its purpose and its beneficiaries. Please attach applicable maps, plans and brochures.

Friendly Faces Homeless Services (FFH) provides a much needed homeless shelter in the East Valley area of the County. FFH is located in Muscoy and operates a 24-hour, full service shelter providing 44 beds for men, women and children. The average length of stay is 60 days, with a maximum of 90 days per client. We also provide clothing, meals and personal care items for our homeless clientele. Our agency conducts outreach through various service organizations in the unincorporated area of Mentone, and the cities of Redlands and Yucaipa. In addition, FFH provides referral outside services to a wide range of service agencies. FFH anticipates serving 250-300 persons during the fiscal year.

While able to provide basic shelter and meal services, FFH plans to expand services to include on-site professional counseling and job training assistance. CDBG funding would allow us to address the unmet needs in support service areas such as counseling, case management, job training and job search assistance. Our agency would like not only to address the immediate shelter needs of our clients, but also assist in the transition towards self-sufficiency.

FFH is a member of the homeless coalition.

Sample

PLEASE SUBMIT COMPLETED PROJECT PROPOSALS TO: San Bernardino County, Department of Economic and Community Development, 290 North "D" Street, Sixth Floor, San Bernardino, CA 92415-0040, Attention: Program and Compliance Section.

For assistance or information regarding the completion of this proposal, call (909) 388-0959. FAX (909) 388-0929.

APPENDIX B

CONTRACT EXHIBITS

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENTProject/Activity Title:Case Number: 330-22027/4033Third District: Homeless Services Program -
Friendly Faces, IncName/Address of Contractor Agency:Date of Issue:

Friendly Faces Homeless Services, Inc.

1234 A Street

Mentone, CA 92001

_____ Original: Beginning

_____ Amendment #

PROJECT/ACTIVITY DESCRIPTION**SERVICES:**

The Friendly Faces Homeless Shelter offers comprehensive shelter and assistance to the homeless. The capacity of the shelter is approximately 50 people. The average occupancy is 40. In a continuing effort to help the needy regain a minimum level of security and self-reliance, the following services will be provided under the terms of this contract:

Shelter: During the term of this contract, the shelter will serve an estimated 1,043 people, providing approximately 14,600 nights of shelter.

Meals: Hot meals will be served three times per day, approximately 43,800 during the contract period.

Specific services to be provided under the terms of this contract are listed below under AUnits of Service.

OPERATIONS:

The shelter is located at 1234 A Street, in Mentone. The office and shelter facility will be open 24 hours per day, seven days per week, with a manager on site at all times. Three meals will be served each day. Counseling and referral services will be offered daily.

UNITS OF SERVICE:

Program activities will be reported in the Monthly Program Progress Report (Exhibit 7 of 8). Performance will be measured using the following units of service:

- (1) Number of shelter nights provided (1 person staying 1 night = 1 unit of service)
- (2) Number of meals served (1 meal served to 1 person = 1 unit of service)

PROGRAM PARTICIPANT PERFORMANCE STANDARDS

A sample of measurable performance standards are as follows:

Homeless Services

Number of Homeless Persons

Measurable Outcomes

- (a) Life survival skills learned by _____ clients
- (b) GED preparation completed by _____ clients
- (c) Job search development skills obtained by _____ clients
- (d) Transitional housing obtained by _____ clients

Sample Standards for Other Kinds of CDBG Programs**CDBG Activity**

1. Literacy Services-Numbers of Illiterate Adults

- (a) Ability to understand and read English
Before: _____ cannot After _____ can
- (b) Capable of reading a paragraph to a tutor
Before: _____ cannot After _____ can
- (c) Ability for participant to demonstrate reading enhancement skills to a reading instructor/tutor
Before: _____ cannot After _____ can

2. At Risk Youth -After School Homework/
Recreational Programs-Numbers of Youth

- (a) Learned to use a computer for homework purposes
Before: _____ cannot After _____ can
- (b) Learned to improve good study habits
Before: _____ cannot After _____ can
- (c) Learned good team effort through recreation/sports program
Before: _____ cannot After _____ can

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:Case Number: 330-22027/4033Third District: Homeless Services Program -
Friendly Faces, Inc.Name/Address of Contractor Agency:Date of Issue:Friendly Faces Homeless Services, Inc.
1234 A Street
Mentone, CA 92001Original: Beginning
Amendment #**BUDGET SUMMARY**

COST CATEGORY	CDBG SHARE \$	OTHER SOURCES \$*	TOTAL COST \$
1) Personnel:	\$ 15,000	\$ 45,000	\$ 60,000
2) Consultant/Contract Services:	4,800	1,900	6,700
3) Travel:	96	-0-	96
4) Space Rental:	3,000	3,000	6,000
5) Consumable Supplies:	3,600	12,000	15,600
6) Rental, Lease, or Purchase of Equipment:	672	1,000	1,672
7) Insurance:	1,452	3,000	4,452
8) Other:	1,380	2,600	3,980
TOTALS	30,000	68,500	98,500

*If costs are to be shared by other sources of funding, including CDBG funds from other jurisdictions, identify the source of funding, grantor/lending agency, and cost category information.

NON-CDBG

United Way	\$ 23,900
Emergency Shelter Grant	19,000
Community Services Department	15,000
Fundraisers	7,000
Donations	3,600
	<u>\$ 68,500</u>

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:Case Number: 330-22027/4033Third District: Homeless Services Program -
Friendly Faces, Inc.Name/Address of Contractor Agency:Date of Issue:

Friendly Faces Homeless Services, Inc.

1234 A Street

Mentone, CA 92001

Original: BeginningAmendment #**BUDGET JUSTIFICATION - PART I (SUPPLIES/SERVICES)**

DESCRIPTION OF ITEM(S) AND BASIS FOR VALUATION		CDBG COST \$	TOTAL COST \$
Budget line			
Item #:			
2.	Consultant/Contract Services:		
	a. Licensed Counselor (LCSW)	4,000	5,200
	2 hours per week @ \$ 50 per hour		
	b. Audit/Accounting Services	<u>800</u>	<u>1,500</u>
		4,800	6,700
3.	Travel	96	96
	266 miles x \$.36 per mile		
4.	Space Rental (1234 AA≅ Street)	3,000	6,000
	\$ 500 per month x 12 months		
5.	Consumable Supplies		
	a. client supplies; toiletries, food, clothing, etc.	3,600	14,000
	b. office supplies; postage, paper, etc.	<u>-0-</u>	<u>1,600</u>
		3,600	15,600
6.	Rental, Lease, Purchase of Equipment	672	1,672
	Copier lease \$ 139/month		
7.	Insurance	1,452	4,452
	General Liability		
8.	Other		
	a. Telephone @ \$ 80/month	480	960
	b. Electricity @ \$ 124/month	600	1,488
	c. Gas @ \$95/month	300	1,140
	d. Job Search Subscriptions & Counseling Materials	<u>-0-</u>	<u>392</u>
		1380	3,980

NOTE: Any budget line item(s) other than salaries and fringe benefits should be detailed above

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:

Case Number: 330-22027/4033

Third District: Homeless Services Program -
Friendly Faces, Inc.

Name/Address of Contractor Agency:

Date of Issue:

Friendly Faces Homeless Services, Inc.

1234 A Street

Mentone, CA 92001

Original: Beginning

Amendment #

INSURANCE INVENTORY**WORKERS' COMPENSATION/EMPLOYERS' LIABILITY INSURANCE**

Name of Insurance Company: _____

Effective Dates: _____

Employer's Liability Limit \$ _____

Certificate of Insurance Attached ☐ Yes ☐ No: On File w/ ECD**COMPREHENSIVE GENERAL AND AUTOMOBILE LIABILITY INSURANCE**

Name of Contractor's General Insurance Company: _____

Limits of Liability

Effective Dates: _____

Per Occurrence \$ _____ Additional Insured Endorsement Attached ☐ Yes ☐ No: On File w/ ECDAnnual Aggregate \$ _____ Certificate of Insurance Attached ☐ Yes ☐ No: On File w/ ECD

Name of Contractor's Automobile Liability Insurance Company: _____

Limits of Liability

Effective Dates: _____

Per Person \$ _____ Per Accident \$ _____ Damage Liability \$ _____ Combined Single Limit \$ _____

ERRORS AND OMISSIONS LIABILITY INSURANCE

Name of Contractor's Insurance Company: _____

Limits of Liability

Effective Dates: _____

Per Occurrence \$ _____ Additional Insured Endorsement Attached ☐ Yes ☐ No: On File w/ ECDAnnual Aggregate \$ _____ Certificate of Insurance Attached ☐ Yes ☐ No: On File w/ ECD**PROFESSIONAL LIABILITY INSURANCE**

Name of Contractor's Insurance Company: _____

Limits of Liability

Effective Dates: _____

Per Occurrence \$ _____ Additional Insured Endorsement Attached ☐ Yes ☐ No: On File w/ ECDAnnual Aggregate \$ _____ Certificate of Insurance Attached ☐ Yes ☐ No:

On File w/ ECD

Sample

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:
Third District: Homeless Services Program -
Friendly Faces, Inc.

Case Number: 330-22027/4033

Name/Address of Contractor Agency:
Friendly Faces Homeless Services, Inc.
1234 A Street
Mentone, CA 92001

Date of Issue:

Original: Beginning
Amendment #

BENEFICIARY QUALIFICATION STATEMENT

This form has the purpose of providing information needed to qualify the use of federal Community Development Block Grant (CDBG) funds for the project/activity described above. This statement must be completed and signed by the person (or legal guardian of the person) requesting to receive benefits from the described project/activity. Only one statement per person, per year is required.

Please answer each of the following questions.

1. This question helps you determine the size of your household. For this question a household is a group of related or unrelated persons occupying the same house with at least one member being the head of the household. Renters, roomers, or borders cannot be included as household members. **How many persons are in your household?** _____
2. This question asks if you are from a low- and moderate-income household. For this question a list of the 2004 LOW-INCOME and LOW- AND MODERATE-INCOME categories* are presented below. Please add up the combined gross annual income of all persons in your household from all sources of income. **In the blank provided, write yes or no, that your combined gross annual income is equal to or less than the LOW-INCOME amount for the number of persons in your household.** _____

In the blank provided, write, yes or no, if your combined gross annual income is equal to or less than the LOW- AND MODERATE-INCOME amount for the number of persons in your household. _____

	Number of Persons in Your Household			
	1	2	3	4
LOW-INCOME	\$19,000	\$21,700	\$24,450	\$27,150
LOW- <u>AND</u> MODERATE-INCOME (COMBINED)	\$30,400	\$34,750	\$39,100	\$43,450

	Number of Persons in Your Household			
	5	6	7	8
LOW-INCOME	\$29,300	\$31,500	\$33,650	\$35,850
LOW- <u>AND</u> MODERATE-INCOME (COMBINED)	\$46,900	\$50,400	\$53,850	\$57,350

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

3. Please indicate how you identify yourself by checking **only one (1)** of the following choices:

	Hispanic	Non-Hispanic
White	<input type="checkbox"/>	<input type="checkbox"/>
Black/African American	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Native Hawaiian/Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaskan Native & White	<input type="checkbox"/>	<input type="checkbox"/>
Asian & White	<input type="checkbox"/>	<input type="checkbox"/>
Black/African American & White	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaskan Native & Black/African American	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Other	<input type="checkbox"/>	<input type="checkbox"/>

4. Please check whether you belong to a Female Headed Household: ☐ Yes ☐ No
5. Please describe the **condition** that would qualify you as being considered in one of the following presumed low- and moderate-income categories: abused child, battered spouse, elderly person, homeless person, disabled adult, illiterate person, or migrant farm worker:
(description) _____

ACKNOWLEDGMENT AND DISCLAIMER

I CERTIFY UNDER PENALTY OF PERJURY THAT INCOME AND HOUSEHOLD STATEMENTS MADE ON THIS FORM ARE TRUE.

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SIGNATURE: _____ PHONE: _____

The information you provide on this form is for Community Development Block Grant (CDBG) program purposes only and will be kept confidential.

*Taken from 2004 Section 8 Low-Income and Very Low-Income Limits.

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:
Third District: Homeless Services Program -
Friendly Faces, Inc.

Case Number: 330-22027/4033

Name/Address of Contractor Agency:
Friendly Faces Homeless Services, Inc.
1234 A Street
Mentone, CA 92001

Date of Issue:
_____ Original: Beginning
_____ Amendment #

DECLARACIÓN DE LA CALIFICACIÓN DEL BENEFICIARIO

Esta forma tiene el propósito de proporcionar la información necesaria para calificar el uso de los fondos federales del bloque del desarrollo de la comunidad (CDBG) para el proyecto/actividad descrito arriba. Esta declaración se debe llenar y firmar por la persona (o la tutela legal de la persona) que solicita para recibir beneficios del proyecto/actividad descrito. Solamente una declaración por persona, por año se requiere.

Conteste por favor a cada una de las preguntas siguientes.

1. Esta pregunta le ayuda a determinar el tamaño de su casa. En esta pregunta un hogar es un grupo de personas relacionadas o sin relación que ocupan la misma casa por lo menos con un miembro que es la cabeza de la casa. Los inquilinos no se pueden incluir como miembros de la casa. ¿Cuántas personas viven en su casa? _____
2. Esta pregunta explica si usted es de un hogar de ingresos bajos y moderados. Para esta pregunta la lista de 2004 de categorías de BAJOS-INGRESOS y del PUNTO BAJO Y de INGRESOS-MODERADOS *se presenta abajo. Suma por favor para arriba los ingresos brutos anuales combinados de todas las personas en su hogar y de todas las fuentes de los ingresos. En el espacio en blanco, escriba sí o no, si su ingreso anual grueso combinado es igual o menos que la cantidad de INGRESO-BAJO para el número de personas en su casa. _____

En el espacio en blanco, escriba, sí o no, si sus ingresos brutos anuales combinados son igual o menos que la cantidad de INGRESOS BAJOS Y MODERADOS para el número de personas en su casa. _____

Numero de Personas en su Hogar				
	1	2	3	4
INGRESOS-BAJOS	\$19,000	\$21,700	\$24,450	\$27,150
INGRESOS-BAJOS Y MODERADOS (COMBINADOS)	\$30,400	\$34,750	\$39,100	\$43,450

Numero de Personas en su Hogar				
	5	6	7	8
INGRESOS-BAJOS	\$29,300	\$31,500	\$33,650	\$35,850
INGRESOS-BAJOS Y MODERADOS (COMBINADOS)	\$46,900	\$50,400	\$53,850	\$57,350

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

3. Indique por favor cómo se identifica usted, marcando solamente una (1) de las opciones siguientes:

	Hispano	No-Hispano
Blanco	<input type="checkbox"/>	<input type="checkbox"/>
Negro/Afro Americano	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Asiático	<input type="checkbox"/>	<input type="checkbox"/>
Indio Americano/Nativo de Alaska	<input type="checkbox"/>	<input type="checkbox"/>
Nativo Hawaiano/Otra Isla del Pacífico	<input type="checkbox"/>	<input type="checkbox"/>
Indio Americano/Nativo de Alaska & Blanco	<input type="checkbox"/>	<input type="checkbox"/>
Asiático & Blanco	<input type="checkbox"/>	<input type="checkbox"/>
Negro/Afro Americano & Blanco	<input type="checkbox"/>	<input type="checkbox"/>
Indio Americano/Nativo de Alaska & Negro/Afro Amer.	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Otro	<input type="checkbox"/>	<input type="checkbox"/>

4. Marque por favor si usted pertenece a un hogar encabezado femenino: ☒ Si ☐ No
5. Describa por favor la condición que le calificaría como siendo considerado en una de las categorías de presumidos ingresos bajos y moderados siguientes: niño abusado, esposo estropeado, persona mayor, persona sin hogar, adulto incapacitado, persona analfabeta, o trabajador migratorio de granja:
(descripción) _____
- _____
- _____

RECONOCIMIENTO Y NEGACIÓN

CERTIFICO BAJO PENA DE PERJURIO QUE LAS DECLARACIONES HECHAS EN ESTA FORMA, ACERCA DE LOS INGRESOS Y DE LAS CUENTAS DE LA CASA SON VERDADERAS.

NOMBRE: _____ FECHA: _____

DOMICILIO: _____ CIUDAD: _____ CODIGO: _____

FIRMA: _____ TELÉFONO: _____

La información que usted proporciona en esta forma es para los propósitos del programa de fondos del bloque del desarrollo de la comunidad (CDBG) solamente y será mantenida confidencial

*Tomado de 2004 Sección 8 Ingresos bajos.

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:
Third District: Homeless Services Program -
Friendly Faces, Inc.

Case Number: 330-22027/4033

Name/Address of Contractor Agency:
Friendly Faces Homeless Services, Inc.
1234 A Street
Mentone, CA 92001

Date of Issue:
_____ Original: Beginning
_____ Amendment #

MONTHLY PROGRAM PROGRESS REPORT AND DIRECT BENEFIT REPORT For the Month of AUGUST, 2002

PART I: MONTHLY PROGRAM PROGRESS REPORT

A. Units of Service Provided and Description

Under each type of service listed below, provide a **NARRATIVE DESCRIPTION** of your program's accomplishments during this month. Include location, number of persons served, services/benefits provided, and a description of the clients served. Also report the number of Units of Service provided, as defined in the Project/Activity Description (Exhibit 1 of 7).

Type of Service:

Anticipated Units of Service:

1. Shelter Nights:

Goal/mo: 1,200 Actual/mo.: 1,182
(1 person staying 1 night = 1 unit of service)

This month we served 7 families with children and 41 individuals, for a total of 68 people. 1,182 shelter nights were provided.

2. Meals Served:

Goal/mo: 3,600 Actual/mo.: 3,146
(1 meal served to 1 person = 1 unit of service)

Total of 3,146 meals were served. The Rotary club prepared and served a barbecue luncheon on the 4th of July.

B. Monthly Beneficiary Count (may include individual persons or households previously counted during this grant/program year)

Total number of beneficiaries (clients/participants) served this month (**choose one category only**):
of Persons _____ OR # of Households _____

PART II: DIRECT BENEFIT REPORT

Direct Benefit Statistics (Unduplicated first-time client counts since start of contract; taken from Beneficiary Qualification Statement forms)

Enter the number of first-time program beneficiaries directly assisted this month

Count only as: ☐ Individual Persons or ☐ Households (check one box)

Low-Income (**only**): _____

Low- **and** Moderate-Income (**combined**): _____

All Beneficiaries: _____

Racial Identity Categories

	Hispanic (a)	Non- Hispanic (b)		Hispanic (c)	Non- Hispanic (d)
White	_____	_____	American Indian/Alaskan Native & White	_____	_____
Black/African American	_____	_____	Asian & White	_____	_____
Asian	_____	_____	Black/African American & White	_____	_____
American Indian/Alaskan Native	_____	_____	Amer. Indian/Alaskan Native & African Amer.	_____	_____
Native Hawaiian/Other Pacific Islander	_____	_____	Balance/Other	_____	_____

Grand Total of Racial Identity Categories. Sum of columns a, b, c, and d should equal the "All Beneficiaries" total above: _____

Female Headed Households: _____

Signed _____ Title _____ Date _____

Printed Name _____ Telephone No./Ext. _____

COUNTY OF SAN BERNARDINO DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title:Third District: Homeless Services Program -
Friendly Faces, Inc.Case Number: 330-22027/4033Name/Address of Contractor Agency:Friendly Faces Homeless Services, Inc.
1234 A Street
Mentone, CA 92001Date of Issue:____ Original: Beginning
____ Amendment #

COMMUNITY BENEFIT REPORT

For the month of _____, 200__

This form has the purpose of providing information on the amount of funds expended to benefit the residents of the communities that funded this project. This is to ensure that services are provided in proportion to the amount of CDBG funds provided as identified by the CDBG contract. Please enter the amount of CDBG funds expended during the month and the number of persons or households served by the expenditure.

Count only as: ☐ Individual Persons or ☒ Households (check one box)

Community	Contract Dollars Allocated	Portion For this Month	Dollars Spent this Month	Persons/ Households Served
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
TOTAL	\$	\$	\$	

Signed _____ Title _____

Printed Name _____ Telephone No./Ext. _____

The following map(s) show the unincorporated areas and boundaries of the Supervisorial District(s) identified above.

APPENDIX C

FUNDING SOURCE SPREADSHEET

EXAMPLE MONTHLY SPREADSHEET
August 2004 – Request for Reimbursement
Friendly Faces Service Project, ECD #330-22027/4033
County Contract #01-1234

SAMPLE

FUNDING SOURCE STATEMENT

Budget Categories:	<u>Total Monthly Cost</u>	<u>County CDBG</u>	<u>Community Services</u>	<u>ESG Program</u>	<u>Client Fees</u>	<u>United Way</u>	<u>Fundraisers & Donations</u>
1. Personnel:							
a. Pgm Coord Operations	1,250	1,250	-0-	-0-	-0-	-0-	-0-
2. Contract/Consultant							
a. Therapist	1,150	400	-0-	750	-0-	-0-	-0-
b. Accountant	180	-0-	45	45	45	45	-0-
3. Travel/Mileage	488	8	210	210	-0-	60	-0-
4. Rent	605	250	125	125	-0-	105	-0-
5. Consumable Supplies:							
a. Postage, Office	116	32	40	40	-0-	4	-0-
b. Client Meals, Clothing	696	268	-0-	-0-	-0-	-0-	428
6. Equipment: Lease (Copier)	283	56	74	75	-0-	39	39
7. Insurance:							
a. General Liability	219	121	33	33	-0-	16	16
8. Other:							
a. Utilities	298	115	50	50	-0-	83	-0-
TOTAL MONTHLY COST:	<u>\$5,285</u>	<u>\$ 2,500</u>	<u>\$577</u>	<u>\$1,738</u>	<u>\$45</u>	<u>\$352</u>	<u>\$483</u>

APPENDIX D

REIMBURSEMENT REQUEST FORMS

CDBG REIMBURSEMENT REQUEST INSTRUCTIONS

Please refer to the following list to ensure that your monthly reimbursement requests are submitted to ECD in a correct and complete manner. This will enable ECD to process your requests as efficiently as possible.

1. Each monthly request must include a completed copy of the following forms containing the following information:

- A. Monthly Report of Grant Expenditures and Request for Reimbursement. In columns one through six, respectively, be sure to include:
- (1) your project account number (found in form header);
 - (2) the total amount of your grant for the current contract;
 - (3) the total amount of the current reimbursement request;
 - (4) the total amount you have been reimbursed to date (after your first reimbursement, this amount can be found in the upper right-hand corner of the latest copy of your Monthly Status of Grant Expenditures spreadsheet);
 - (5) the total amount you will have been reimbursed, including the current request;
 - (6) the remaining balance (subtract column 5 from column 2).

B. Summary of Expenses. Include total amount requested under each budget line item category.

C. Itemized Expenses. Under the proper budget item heading, list a brief description and the amount of each expenditure claim in the space provided. This description should include the check number corresponding to the check used to pay for the indicated goods or services.

D. Monthly Program Progress Report: One copy of this form, found as the last exhibit in your current contract, must be completed for each program month during the life of your contract. (See Section 4-23, 4-24 and Appendix B of the Subrecipient Manual.)

NOTE: If applicable, you may substitute your own time cards and mileage logs, provided the forms furnish the same information as ECD's forms.

2. Please be sure to fill out all forms completely, including all signatures and dates where necessary. Please submit forms with **original signatures in ink** only. No photocopied signatures please.

3. For each expenditure claimed for reimbursement remember to include all appropriate support documentation. This will include:

A. Method of Payment This must take the form of documented proof that each payment claimed for reimbursement has actually been disbursed. (e.g. endorsement copy of canceled check, credit card receipt with proof of payment, payroll register, bank statement showing relevant debited amounts, etc.), AND;

B. Justification and/or Proof of Expenditure This must clearly show what was purchased and when it was purchased. (e.g. billing statement or requisition, receipt or itemized invoice describing the goods and services purchased. See Sections 5-1 through 5-3 of the Manual).

REIMBURSEMENT REQUEST INSTRUCTIONS FOR COUNTY DEPARTMENTS

Please refer to the following list to ensure that your monthly reimbursement requests are submitted to ECD in a correct and complete manner. This will enable ECD to process your requests as efficiently as possible.

1. Each monthly request must include a completed copy of the following forms containing the following information:

(a) Monthly Report of Grant Expenditures and Request for Reimbursement: In columns one through six, respectively, be sure to include:

- (1) your project account number (found in form header);
- (2) the total amount of your grant for the current contract;
- (3) the total amount of the current reimbursement request;
- (4) the total amount you have been reimbursed to date (after your first reimbursement, this amount can be found in the upper right hand corner of the latest copy of your Monthly Status of Grant Expenditures spreadsheet);
- (5) the total amount you will have been reimbursed, including the current request;
- (6) the remaining balance (subtract column 5 from column 2).

(b) Summary of Expenses: Include total amount requested under each budget line item category.

(c) Itemized Expenses: Under the proper budget item heading, list a brief description and the amount of each expenditure claim in the space provided. This description should include the check number corresponding to the check used to pay for the indicated goods or services. If expenditure was paid via FAS, include document ID number.

(d) Weekly Time Card: You may submit this form in lieu of TLR copies, if your department deems it preferable to do so due to confidentiality concerns. Use this form to indicate hours charged to CDBG and submit appropriate support documentation for wage reimbursement as described below.

2. Please be sure to fill out all forms completely, including all signatures and dates where necessary. Please submit forms with **original signatures in ink** only. No photocopied signatures please.

3. For each expenditure claimed for reimbursement, remember to include all appropriate support documentation. This will include:

A. Method of Payment: This must take the form of documented proof that each payment claimed for reimbursement has actually been disbursed, (e.g. endorsement copy of canceled check, page of image checks supported by the corresponding bank statement, credit card receipt with proof of payment, payroll register, bank statement showing relevant debited amounts, etc.); AND,

B. Justification and/or Proof of Expenditure: This must clearly show what was purchased and when it was purchased, (e.g. billing statement or requisition, receipt or itemized invoice describing the goods and services purchased. See sections 5-1 through 5-3 of the Manual).

COUNTY OF SAN BERNARDINO

DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Multi-District: Homeless Services Program - Friendly Faces	Case #: 123-00127/0000 P.O./Contract #: (to be completed by ECD) Vendor I.D.: F R I E N D L 000
Subrecipient Name and Address: Friendly Faces Homeless Services, Inc. 1234 A Street Anytown, CA 92001	Proj. Effective: 07/01/04 - 06/30/05 Month of: August Invoice #: 02 From: 08/01/04 To: 08/01/04

MONTHLY REPORT OF GRANT EXPENDITURES AND REQUEST FOR REIMBURSEMENT

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Proj./Case Acct. No.	Grant Amount	Current Month	Cumulative Prior Reimb	Cum. Reimb.	Grant Balance
123-00127/0000	\$30,000	\$2,500	\$2,500	\$5,000	\$25,000

I CERTIFY THAT, (a) the County of San Bernardino, as grantee of the CDBG, has not previously been billed for the costs covered by this invoice, (b) funds have not been received from the Federal Government or expended for such costs under the terms of the contract agreement or grant pursuant to FMC-74-4 & 24 CFR Part 58; (c) all applicable provisions under the terms of the contract agreement or grant relating to the payment of prevailing salaries and wages have been complied with; and (d) all applicable tax laws are complied with.

PREPARED BY: <i>Bookkeeper / Prog. Administrator, etc.</i>	Ph#:	APPROVED BY: <i>Executive Director (or Board Chairperson)</i>	Date:
PRINT NAME:		PRINT NAME:	
PROGRAM AGENT USE			
Audited By:	Examined By:	Approved By:	

Note: A detailed breakdown of costs expended must be attached to each Request for reimbursement and Verified by authorized signature.

COUNTY OF SAN BERNARDINO	
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT	
Project/Activity Title: Multi-District: Homeless Services Program - Friendly Faces	Case #: 123-00127/0000 P.O.NUMBER: (to be completed by ECD) Vendor I.D.: F R I E N D L 000
Subrecipient Name and Address: Friendly Faces Homeless Services, Inc. 1234 A Street Anytown, CA 92001	Proj. Effective: 07/01/04 - 06/30/05 Month of: August Invoice #: 02 From: 08/01/04 To: 08/31/04
<u>SUMMARY OF EXPENSES</u>	
1. WAGES & FRINGE BENEFITS	\$1,250.00
2. CONSULTAT/CONTRACT SERVICES	400.00
3. TRAVEL	9.00
4. SPACE RENT	250.00
5. CONSUMABLE SUPPLIES	300.00
6. RENTAL/LEASE/PURCHASE OF EQUIPMENT	55.00
7. INSURANCE	121.00
8. OTHER/MISC.	115.00
TOTAL MONTHLY REIMBURSEMENT \$	2,500.00
PREPARED BY:	DATE:
APPROVED/	
VERIFIED BY:	DATE:

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Multi-District: Homeless Services Program - Friendly Faces
--

Case #:	123-00127/0000
P.O.NUMBER:	(to be completed by ECD)

Sub-Recipient Name and Address
Friendly Faces Homeless Services, Inc. 1234 A Street Anytown, CA 92001

Proj. Effective: 07/01/04 - 06/30/05			
Month of: August		Invoice #: 02	
From: 8/01/04		To: 8/31/04	

<u>ITEMIZED EXPENSES</u>	
---------------------------------	--

1. WAGESFRINGES			CHECK#	CDBG	\$	5. CONSUMABLES			CHECK #	CDBG	\$
Wages -		14851	1,150.03	Office Supply Depot		1277	124.78				
Counselor 49 hrs. @ 23.47/hr.				Wholesale Outlet		1292	160.76				
Fringes - FICA (7.65% of gross) Workers' Comp.				Groceries for Less (coffee & creamer)		1275	14.46				
Requested Amount Total:			\$	1250.00	Requested Amount Total:			\$	300.00		
2. CONTRACT/CONSULTANTS			CHECK#	CDBG	\$	6. RENTAL/LEASE PUR. EQUIP			CHECK #	CDBG	\$
Accountant		1285	400.00	Photocopier Lease		1283	55.00				
Requested Amount Total:			\$	400.00	Requested Amount Total:			\$	55.00		
3. TRAVEL			CHECK#	CDBG	\$	7. INSURANCE			CHECK #	CDBG	\$
25 miles @ \$0.36/mi.		1288	9.00	TransfeRisk Insurance Co.		1268	121.00				
Requested Amount Total:			\$	9.00	Requested Amount Total:			\$	121.00		
4. SPACE RENT			CHECK#	CDBG	\$	8. OTHER/MISC			CHECK #	CDBG	\$
Smith Management		1287	250.00	Electric Company		1266	47.53				
				Telephone Service		1290	67.47				
Requested Amount Total:			\$	250.00	Requested Amount Total:			\$	115.00		
PREPARED BY:						DATE:					
APPROVED BY:						DATE:					

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Multi-District: Homeless Services Program - Friendly Faces	Case #: 123-00127/0000 P.O.NUMBER: (to be completed by ECD) Vendor I.D.: F R I E N D L 000
Subrecipient Name and Address: Friendly Faces Homeless Services, Inc. 1234 A Street Anytown, CA 92001	Proj. Effective: 07/01/04 - 06/30/05 Month of: August Invoice #: 02 From: 8/1/2004 To: 8/31/2004

WEEKLY TIME CARD
 (List hours charged to CDBG only.)

EMPLOYEE NAME John Doe POSITION TITLE: Counselor

DATE/PAY PERIOD	MON	TUE	WED	THUR	FRI	SAT	SUN	WEEKLY HOURS
8/01 through 8/05	2.5	3	2	1.5	0.5			9.5
8/09 through 8/12	1.5	2	3.5	2	1			10.0
8/15 through 8/19	2	1.5	2.5	0	0.5			6.5
8/22 through 8/26	1	3.5	2	1.5	2			10.0
8/29 through 8/31	4	4.5	4.5					13.0
WEEKLY / MONTHLY TOTAL								49.0

 EMPLOYEE SIGNATURE DATE

 SUPERVISOR SIGNATURE DATE

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Multi-District: Homeless Services Program - Friendly Faces	Case #: 123-00127/0000 P.O.NUMBER: (to be completed by ECD) Vendor I.D.: F R I E N D L 000
Subrecipient Name and Address: Friendly Faces Homeless Services, Inc. 1234 A Street Anytown, CA 92001	Proj. Effective: 07/01/04 - 06/30/05 Month of: August Invoice #: 02 From: 8/1/2004 To: 8/31/2004

VEHICLE MILEAGE RECORD

EMPLOYEE NAME: _____

DATE	DEPARTURE (beginning mileage)	DESTINATION (ending mileage)	MILEAGE RECORDED	PURPOSE
8/4/2003	47865	47868	3	Office Supply Store
8/8/2003	47932	47938	6	Grocery Shopping
8/15/2003	48096	48104	8	Meeting w/Homeless Commission
8/22/2003	48427	48431	4	Drop off Bank Deposits
8/25/2003	48544	48548	3	Office Supply Store

Total Miles recorded:	24
Total Miles @ \$0.375/mi.	\$9.00

EMPLOYEE SIGNATURE	DATE
SUPERVISOR SIGNATURE	DATE

APPENDIX E

CITY/COUNTY DEPARTMENTS REIMBURSEMENT REQUEST FORM

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Silver Springs - Youth Recreation Program	Case #: 320-22927/1562 Revision: #6 Cooperration Agreement A&B dated 7/01/03 <p style="text-align: right;">CITY OF S 012</p>
Subrecipient Name and Address: Cooperating City 1234 First Street Cooperating City, CA 98765	Proj. Effective: 07/01/04 - 06/30/05 Month of: Invoice #: From: To:

MONTHLY REPORT OF GRANT EXPENDITURES AND REQUEST FOR REIMBURSEMENT

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Proj./Case Acct. No.	Grant Amount	Current Month	Cumulative Prior Reimb	Cum. Reimb.	Grant Balance

I CERTIFY THAT, (a) the County of San Bernardino, as grantee of the CDBG, has not previously been billed for the costs covered by this invoice, (b) funds have not been received from the Federal Government or expended for such costs under the terms of the contract agreement or grant pursuant to FMC-74-4 & 24 CFR Part 58; (c) all applicable provisions under the terms of the contract agreement or grant relating to the payment of prevailing salaries and wages have been complied with; and (d) all applicable tax laws are complied with.

PREPARED BY: Ph#:	APPROVED BY: Date:
PRINT NAME:	PRINT NAME:
PROGRAM AGENT USE	
Audited By:	Examined By: Approved By:

Note: A detailed breakdown of costs expended must be attached to each Request for reimbursement and Verified by authorized signature.

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Project/Activity Title: Multi-District: Code Enforcement	Case #: 350-12345/1234 REVISION# 01 A & B date of original issue: 7/01/03 FAS Accounting Codes: RST-UVW-XYZ-123-4567
Subrecipient Name and Address: S.B. County Office of Code Enforcement 1234 County Road San Bernardino, CA 92415	Proj. Effective: 7/01/04 - 6/30/05 Month of: Invoice #: From: To:

MONTHLY REPORT OF GRANT EXPENDITURES AND REQUEST FOR REIMBURSEMENT

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Proj./Case Acct. No.	Grant Amount	Current Month	Cumulative Prior Reimb	Cum. Reimb.	Grant Balance

I CERTIFY THAT, (a) the County of San Bernardino Department of Economic and Community Development, as grantee of the CDBG, has not previously been billed for the costs covered by this invoice, (b) funds have not been received from the Federal Government or expended for such costs under the terms of the contract agreement or grant pursuant to FMC-74-4 & 24 CFR Part 58; (c) all applicable provisions under the terms of the contract agreement or grant relating to the payment of prevailing salaries and wages have been complied with; and (d) all applicable tax laws are complied with.

PREPARED BY:	Ph#:	APPROVED BY:	Date:
PRINT NAME:		PRINT NAME:	
PROGRAM AGENT USE			
Audited By:	Examined By:	Approved By:	

Note: A detailed breakdown of costs expended must be attached to each Request for reimbursement and Verified by authorized signature.

APPENDIX F

EXPENDITURE/BUDGET SPREADSHEET

UPDATED THRU: AUG. 2004 - INV.#02 VENDOR ID # A B C D E F G 123
 FRIENDLY FACES HOMELESS SERVICES, INC.
 330-22027/0000 CONTRACT #04-0000
 7-01-04 TO 6-30-05

CBO MONTHLY STATUS OF EXPENDITURES 15-Sep-03

CUMMULATIVE REIMBURSEMENT
 TO DATE: **\$5,000.00**

BUDGET LINE ITEMS	BUDGET	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	BALANCE	% used	% remaining
1 WAGESFRINGE BENEFITS	\$15,000.00	\$1,250.00	\$1,250.00											\$12,500.00	17%	83%
2 CONSULTANT/CONTRACT SERVICES	\$4,800.00	\$400.00	\$400.00											\$4,000.00	17%	83%
3 TRAVEL (@ 34.5 cents per mile)	\$96.00	\$8.00	\$8.00											\$80.00	17%	83%
4 SPACE RENTAL	\$3,000.00	\$250.00	\$250.00											\$2,500.00	17%	83%
5 CONSUMABLES	\$3,600.00	\$300.00	\$300.00											\$3,000.00	17%	83%
6 RENT/LEASE/REPAIR/PURCHASE Equip.	\$672.00	\$56.00	\$56.00											\$560.00	17%	83%
7 INSURANCE (general liab. & auto)	\$1,452.00	\$121.00	\$121.00											\$1,210.00	17%	83%
8 OTHER/Misc.	\$1,380.00	\$115.00	\$115.00											\$1,150.00	17%	83%
TOTALS	\$30,000.00	\$2,500.00	\$2,500.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25,000.00	17%	83%

INDIVIDUAL WAGE DISTRIBUTION

BUDGET LINE ITEM #01 - Wages/Benefits	BUDGET	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	BALANCE	% used	% remaining
1 WAGE/BENEFITS- Project Coordinator Jane Doe @ \$15.00 / hr.	\$6,000.00	\$500.00	\$500.00											\$5,000.00	17%	83%
2 WAGE/BENEFITS- Site Manager John Doe @ \$12.50 / hr.	\$3,500.00	\$291.67	\$291.67											\$2,916.66	17%	83%
3 WAGE/BENEFITS- Intake Specialist Rachel Roe @ \$10.00 / hr.	\$3,000.00	\$250.00	\$250.00											\$2,500.00	17%	83%
4 WAGE/BENEFITS- Clerk Richard Roe @ \$7.50 / hr.	\$2,500.00	\$208.33	\$208.33											\$2,083.34	17%	83%
TOTALS	\$15,000.00	\$1,250.00	\$1,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$12,500.00	17%	83%

APPENDIX G

MONITORING CHECKLIST

COUNTY OF SAN BERNARDINO
DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

Community Based Organization
Office Monitoring Visit

Visit Date: _____

ECD Staff: _____

Organization: _____

Interviewee: _____

Items for Review:

PROGRAM FILES

General Program Files

Necessary records pertaining to the CDBG funded program, properly filed and labeled, including, but not limited to:

- _____ Incorporation documents
 - _____ Bylaws
 - _____ Articles of incorporation
 - _____ Other _____
- _____ Board of Directors actions/minutes
- _____ Program needs assessments
- _____ Citizen comments, complaints or letters of appreciation
- _____ General correspondence, public and County
- _____ Program Policies
 - _____ Client fee schedules
 - _____ Personnel policies
 - _____ Fringe benefit plans
 - _____ Other _____
- _____ Service contract with the County
- _____ Certified insurance policies and certificates of insurance
- _____ Fiscal documents, including expenditure documentation
 - _____ Invoices
 - _____ Receipts
 - _____ Time cards
 - _____ Pay stubs
 - _____ Canceled checks
 - _____ Mileage records
 - _____ Other _____
- _____ Program audit and pertinent correspondence.
- _____ An accurate and complete listing of CDBG funded equipment or vehicles is kept on file, including make, model, serial number, purchase price, and use location.
- _____ Other _____

Contract Activity Files

Files for each separately funded CDBG service/activity, properly filed and labeled, containing:

- _____ Activity descriptions, including goals, objectives, units of service to be provided, client target groups, other funding sources, etc.
- _____ Notices and advertisements
- _____ Correspondence pertaining to the service/activity
- _____ Sub-contracts and procurement records
- _____ Client direct benefit documentation (client counts by ethnicity and female headed households) kept current, without double counting of clients.
- _____ Activity progress documentation
- _____ Other _____

CONTRACT PROVISIONS

Monthly Reports

- ☐ Monthly activity accomplishment reports have been submitted to the County
- ☐ Direct benefit activity forms have been submitted to the County (monthly, quarterly, annually)
- ☐ Adequate program progress indicated
- ☐ Units of service provided per the terms of the CBO agreement

Fiscal Management

- ☐ The CBO has a fiscal system which accurately tracks its financial condition, containing:
 - ☐ Fiscal tracking system including reports on program allocations, obligations, expenditures, balances and totals.
 - ☐ Program income documentation showing revenue, expenditures, profit/loss, and net income generated directly from use of CDBG funds.
 - ☐ Cash management policies, including petty cash transaction records.
- ☐ County has authorized all budget amendments.

Audits

- ☐ County ECD has received a copy of the most recent audit under the Federal Single Audit Act.
- ☐ All CBO audit findings regarding CDBG funds have been adequately addressed and resolved.

Insurance

- ☐ CBO maintain throughout the term of the CBO agreement the following types of insurance:
 - ☐ Worker's Compensation
 - ☐ Comprehensive General and Automobile Liability
 - ☐ Errors and Omissions Liability
 - ☐ Professional Liability
- ☐ All stipulations (including "primary and non-contributing" and "subrogation rights against County waived"), endorsements, and coverage's required by the CBO agreement are contained in the insurance documents.

Clientele Income Qualification

- ☐ Clientele Income Documentation meets the requirements of the CBO agreement
- ☐ List of HUD Section 8 Income limits is current

Service Performance

- ☐ Program performance follows the schedule outlined in the CBO agreement
- ☐ Program provides full scope of services defined in the agreement
- ☐ Performance quality is consistent with the terms of the agreement

Equipment

- ☐ Equipment is used for the funded service and is well maintained
- ☐ County has authorized all non-expendable project purchases

American Disability Act (ADA)

- ☐ Evaluation of the facility program accessibility for disabled individuals
- ☐ Path of Travel - accessible route from the nearest bus stop, parking lot, public streets and sidewalks to the facility entry door
- ☐ Evaluation of parking stalls for handicapped parking
- ☐ A ramp to allow an accessible entrance for disabled individuals up to the facility entry door
- ☐ Space requirements of wheelchair passage for entry doorways
- ☐ Wheelchair turning space within the facility
- ☐ Wheelchair accessibility into Public Restrooms within the facility.

OBSERVATIONS/COMMENTS: _____

APPENDIX H

INCOME STATEMENT

San Bernardino County
Department of Economic and Community Development
Community Development Block Grant (CDBG) Program

Income Statement

Project/Activity: Homeless Shelter Program - Friendly Faces
ECD Project/Case: 330-23027/0000
Contract: 2003-2004
Contract Term: July 1, 2003 through June 30, 2004
Reporting Period: July 1, 2003 through June 30, 2004

Please enter only those sources of revenue and only those expenditures that pertain to providing the CDBG funded activity under the CDBG contract identified above.

FUNDING: County Community Development Block Grant (CDBG) funding.

1. Enter the dollar amount of CDBG funded program assistance received under contract with San Bernardino County during the reporting period as the Funding Received on Line 1.

Funding Received (Line 1) \$ 50,000

INCOME: Gross income directly generated by the use of CDBG funds or CDBG financed property.

1. Enter the dollar amounts of income received from sales and/or services during the reporting period.
2. Add these amounts as Total Income Collected on Line 2.

Sale of CDBG funded equipment or property
Fees collected for CDBG funded service

\$ 10,000
\$ 40,000

Total Income Collected (Line 2) \$ 50,000

FUNDING/INCOME TOTAL: To determine gross income of CDBG funded program.

1. Combine CDBG Funding Received (Line 1) with total Income Collected (Line 2) as Funding/Income Total on Line 3.

Funding/Income Total (Line 3) \$ 100,000

EXPENDITURES: Actual cost of providing the CDBG funded service.

1. Enter the dollar amount of each program expenditure category directly related to providing CDBG funded service.
2. Add these amounts and enter as Total Expenditures on Line 4.

Accounting/Bookkeeping	\$ <u> </u>	Rent/Lease	\$ <u> </u>
Auditing/Financial Reports	<u>1,500</u>	Salaries & Wages (With Benefits)	<u>68,300</u>
Advertising	<u> </u>	Supplies	<u>12,000</u>
Insurance	<u>3,000</u>	Taxes (Employee Fed. & State)	<u>3,000</u>
Maintenance	<u> </u>	Utilities	<u>520</u>
Mileage	<u>480</u>	Other <u>food</u>	<u>9,200</u>
Phone	<u> </u>	Other <u> </u>	<u> </u>

Total Expenditures (Line 4) \$ 98,000

GAIN/LOSS: To determine net income of CDBG funded program.

1. Subtract **Total Expenditures** (Line 4) from Funding/Income Total (Line 3) and enter Result on Line 5.
2. If Line 5 is a zero or negative amount check the Loss box below.
3. If Line 5 is a positive amount check the Gain box below.

Result (Line 5) \$ 2,000

GAIN ☒ *(Program Income)

LOSS ☐ (no Program Income)

I hereby certify that the above information given is correct to the best of my knowledge.

NAME: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

*Program Income: Gross income received by the subrecipient directly generated from the use of CDBG funds. (Ref.: 24 CFR 570.500(a))

APPENDIX I

CONTRACT MODIFICATION REQUEST SAMPLE LETTER

CONTRACT MODIFICATION REQUEST SAMPLE LETTER

Date: _____

Mr. Thomas R. Laurin, Director
San Bernardino County
Department of Economic and Community Development
290 North "D" Street, Sixth Floor
San Bernardino, CA 92415-0040

RE: _____ **PROGRAM – ECD #** _____ - _____ / _____;
CONTRACT OR PURCHASE ORDER NUMBER: _____ - _____

Dear Mr. Laurin:

Due to (reason for request – use another sheet of paper if necessary) _____,
we are requesting a modification to our current contract's budget. Therefore, pursuant to the contract's
section number 6; Budget MODIFICATIONS, we request the following:

PROPOSED NEW BUDGET SUMMARY

Line Item #:	Cost Category	CDBG SHARE \$		OTHER SOURCES \$		TOTAL COST \$	
		Current	Proposed	Current	Proposed	Current	Proposed
1	Personnel						
2	Consultant/ Contract Services						
3	Travel						
4	Space Rental						
5	Consumable Supplies						
6	Rental, Lease or Purchase of Equip't						
7	Insurance						
8	Other						
	TOTALS:		CDBG SHARE \$		OTHER SOURCES \$		TOTAL COST \$

Modifications to Other Sources of Funding: _____

Sincerely,

Attachment

**PROPOSED NEW
BUDGET JUSTIFICATION - PART I (SUPPLIES/SERVICES)**

DESCRIPTION OF ITEM(S) AND BASIS FOR VALUATION	CDBG COST \$	TOTAL COST \$
Budget line Item #:		
2. Consultant/Contract Services:		
3. Travel:		
4. Space Rental:		
5. Consumable Supplies:		
6. Rental, Lease or Purchase of Equipment:		
7. Insurance:		
8. Other:		
TOTALS	\$	\$

NOTE: Any budget line item(s) other than salaries and fringe benefits should be detailed above.

NEW PROPOSED
BUDGET JUSTIFICATION - PART II (PERSONNEL)

A) WAGES:					
POSITION/TITLE	ACTUAL HOURLY RATE (SALARY) \$	# HOURS PER WEEK	MONTHS TO BE EMPLOYED	TOTAL COST \$	CDBG COST \$

Subtotal:

B) FRINGE BENEFITS: _____

TYPE OF COSTS	PERCENT OF SALARY/CALCULATIONS	TOTAL COST \$	CDBG COST \$
FICA	%		
SUI	%		
WORKER'S COMP.	%		
HEALTH	%		
LIFE INSURANCE			

Subtotal:

TOTAL COST OF PARTS A & B
(Must be the same as Budget Line Item #1 in Budget Summary) _____

APPENDIX J

INSURANCE REQUIREMENTS MATRIX

INSURANCE REQUIREMENTS FOR COUNTY-WIDE CONTRACTS

REQUIREMENTS	Construction, Repair and Maintenance	Design Consultant w/Construction Work	Architectural	Engineer	General Consultants	Environmental & Air Quality Consultants	Service	Legal/Medical Professionals (individuals)	Legal/Medical (groups)	Contract Employees*	*State	Request for Proposals	Solid Waste	Lessee	Professional Services
1 Hold Harmless	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
2 Subro Waiver	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
3 Addtl. Insured	✓	✓	✓	✓	✓	✓	✓		✓			✓	✓	✓	✓
4 Primary Non- Cont.	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
5 30-Day Cancellation	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
6 Errors and Omissions	✓	✓	✓	✓	✓				✓			✓	✓	✓	✓
7 Comp. Auto. Liability	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
8 Comp. Gen. Liability	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
9 Professional Liability			✓					✓	✓			✓			✓
10 Workers' Compensation	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
11 Insurance Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12 Workers' Comp for contractors with no employees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Use their language.

APPENDIX K

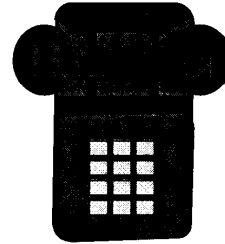
SPARTA INSURANCE PROGRAM

S P A R T A

*SERVICE PROVIDERS & ARTISAN TRADESMAN ACTIVITIES
COMMERCIAL GENERAL LIABILITY, NON-OWNED AUTOMOBILE LIABILITY
AND PROFESSIONAL LIABILITY PROGRAM*

ATTENTION

*County of San Bernardino
Consultants, Contractors,
Service Providers & Tenants*



TOLL FREE 1-800-420-0555
**PREAPPROVED BY THE COUNTY OF
SAN BERNARDINO**

*AVAILABLE TO GENERAL CONTRACTORS,
CONSULTANTS, SUBCONTRACTORS & TENANTS
\$1M TO \$5M LIMITS ON GENERAL LIABILITY,
PROFESSIONAL LIABILITY & NON-OWNED AUTO
MISCELLANEOUS MEDICAL MALPRACTICE
COVERAGE ISSUED FOR CONTRACT PERIODS
FROM 1 DAY TO ANNUAL
HASSLE-FREE APPLICATIONS
WE DO ALL THE PAPERWORK
24-HOUR RESPONSE TIME
IMMEDIATE COVERAGE!*

NO OBLIGATION QUOTES

Municipality Insurance Services, Inc.
1920 E. 17th Street, Ste.136, Santa Ana, CA 92705
License # OCO4849 Web site: www.2sparta.com

SPARTA

SPARTA is an insurance program that was developed to accommodate small contractors who need an alternative to high cost general liability insurance. This program should prove very beneficial to local minority, women and disabled veteran owned businesses. This program has been preapproved by the County of San Bernardino and the application process is simple. Coverage is affordable. This program is available to County contractors.

Coverage:

- I. General Liability: Program limits, \$2MM General Aggregate/\$1MM Per Occurrence, limits to 5MM available, \$500 deductible per claim. Meets all minimum requirements for the County of San Bernardino. Applicable bodily injury and property damage caused by contractor's activities while under contract to the County of San Bernardino.
 - II. Non-Owned Auto Liability: Coverage applies only the the County of San Bernardino al limited by the specific work performed under this certificate. No coverage afforded to certificate holder.
 - III. Professional Liability: In conjunction with General Liability only. Service contractor Minimum Premium: \$250.00 + SLA taxes + certificate fee. Quoted on a per-project basis.
 - IV. Misc. Medical Malpractice: In conjunction with General Liability only.
- Participants in SPARTA:** The County of San Bernardino, its Departments, and Certificated Service Providers and/or Artisan Trade Activities Contractors participating in the County of San Bernardino SPARTA Program
- Type of work covered:** Personal services contracts
General contractors and their subcontractors
(Certain specialty trades are excluded)
- Contract Size and Cost:** No maximum: all contract sizes considered
Minimum: No contract minimum
General Liability Service Contractor Minimum Premium: \$250.00 + SLA taxes + certificate fee. General Liability Artisan Contractor Minimum Premium: \$450.00 + SLA taxes + certificate fee.

Underwritten by Essex Insurance Company, rated A9 by A.M. Best Company

Master policy issued annually to cover contracts with the County of San Bernardino
Certificate is issued showing contractor participation in master program

SPARTA coverage is limited to contracts of the County of San Bernardino but can be endorsed to include coverage for parties involved in a joint effort with the County of San Bernardino

Administered by Municipality Insurance Services, Inc.

1920 E. 17th Street, Ste. 136

Santa Ana, CA 92705

License No. OCO4849

FOR MORE INFORMATION, CALL THE SPARTA OFFICE AT

1-800-420-0555

OR VISIT OUR WEB SITE AT

WWW.2SPARTA.COM

APPENDIX L

CIMA - VOLUNTEER INSURANCE PROGRAM

This document can be viewed at the following Web site:

<http://www.cimaworld.com/files/brochure.pdf>

APPENDIX M

ACCESSIBLE WHEELCHAIR SPACE REQUIREMENTS

ACCESSIBLE WHEEL CHAIR SPACE REQUIREMENTS

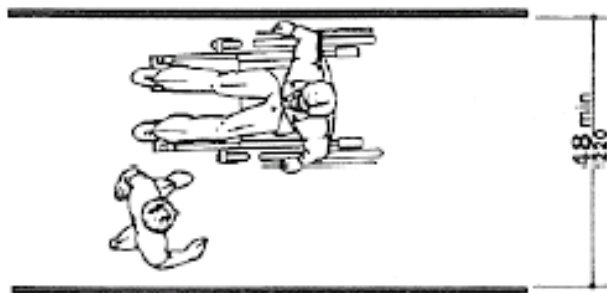


Fig. A1
Minimum Passage Width for One Wheelchair
and One Ambulatory Person

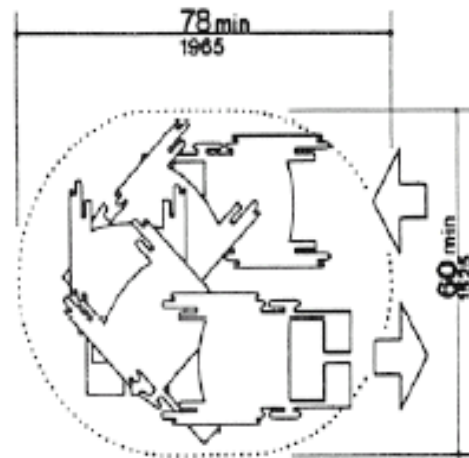
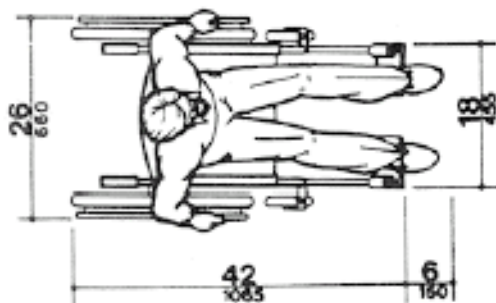
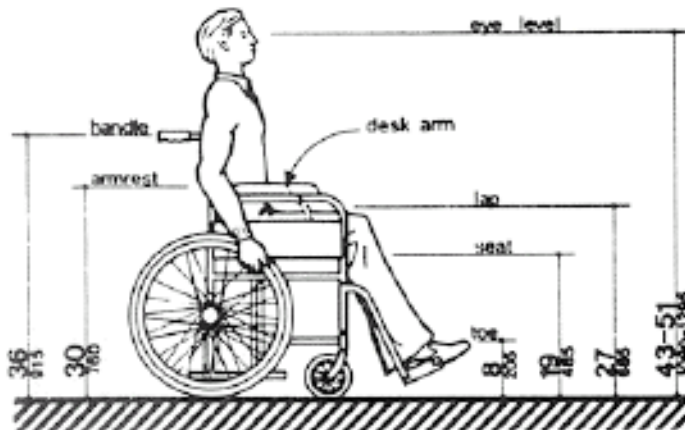


Fig. A2
Space Needed for Smooth U-Turn in a Wheelchair



NOTE: Footrests may extend further for tall people

Fig. A3
Dimensions of Adult-Sized Wheelchairs

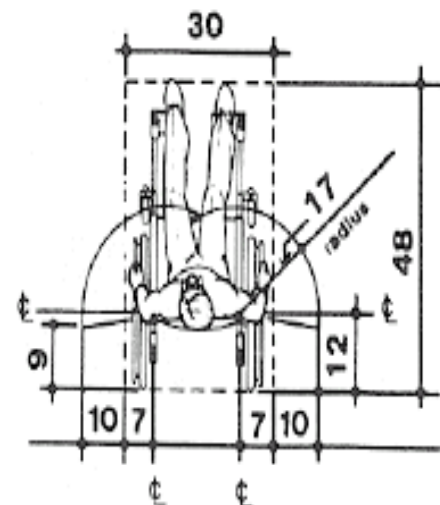
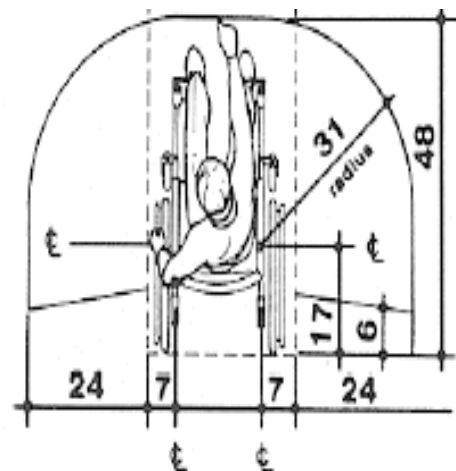


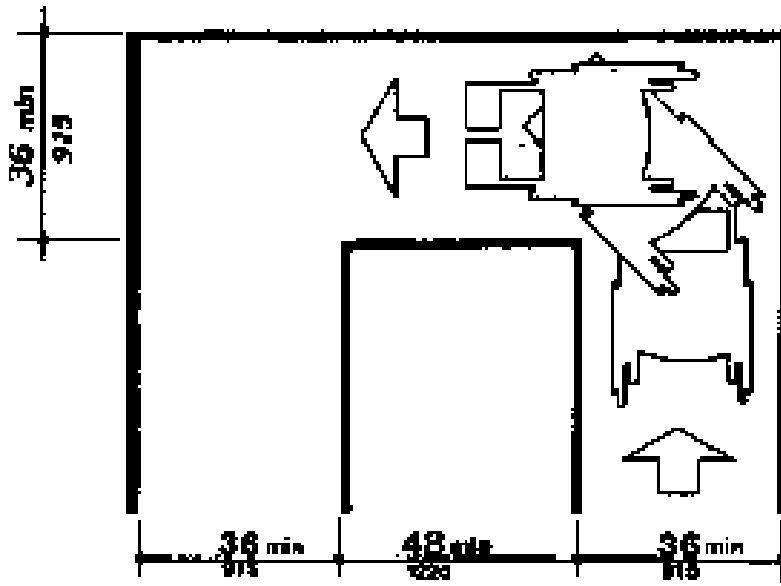
Fig. A3 (a)

Fig A1, A2, A3, A3(a): Department of Justice, Code of Federal Regulations - Excerpt from 28 CFR Part 36: ADA Standards for Accessible Design; 28 CFR Ch.1 (7-1-94 Edition), pg. 565-566.
[Electronic Version] <http://www.usdoj.gov/crt/ada/adastd94.pdf>

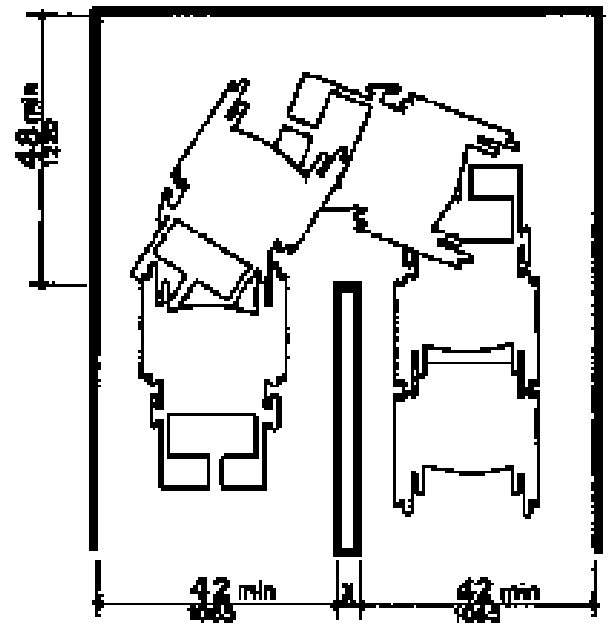
APPENDIX N

ACCESSIBLE WHEELCHAIR PATH OF TRAVEL REQUIREMENTS

ACCESSIBLE WHEEL CHAIR PATH OF TRAVEL SPACE REQUIREMENTS

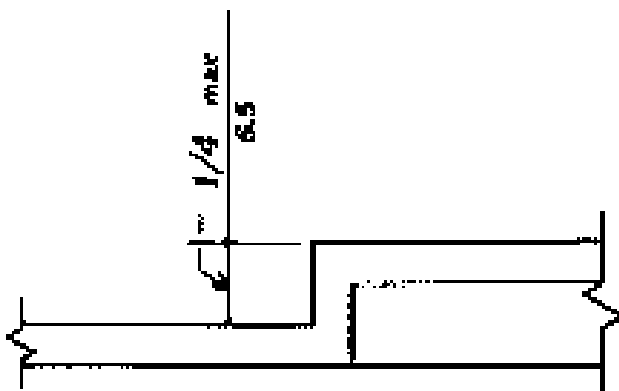


(a)
90° Turn

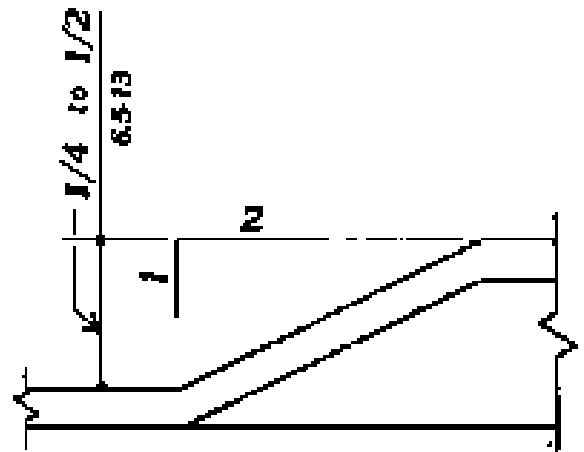


(b)
Turns around an Obstruction

NOTE: Dimensions shown apply when $x \leq 48$ in (1220 mm).



(c)
Changes in level



(d)
Changes in level

Fig. 7
Accessible Route

Fig. 7: Department of Justice, Code of Federal Regulations - Excerpt from 28 CFR Part 36: ADA Standards for Accessible Design; 28 CFR Ch.1 (7-1-94 Edition), pg. 511.
[Electronic Version] <http://www.usdoj.gov/crt/ada/adastd94.pdf>

APPENDIX O

AMERICANS WITH DISABILITIES ACT ADA GUIDE FOR SMALL BUSINESSES

This report can be viewed at the following Web site:

<http://www.usdoj.gov/crt/ada/smbusgd.pdf>